

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10063

CERTIFICATE OF DEATH

10043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bunkie, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>County Hosp.</u>				e. STREET ADDRESS <u>Prince Frederick</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>B</u> Last <u>Booge</u>				4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-1890</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Booge</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Waters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Arthur Booge, Bunkie, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/25</u> , 19 <u>59</u> , to <u>9/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>59</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. E. Sewell</u> M.D.				ADDRESS (Street, city or town, state) <u>58 Henry</u>			
PHYSICIAN'S NAME (Type) <u>P. E. Sewell</u>				DATE SIGNED <u>9/29/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-29-59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Hallacreek</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>				ADDRESS <u>Prince Frederick</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton St. James</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death.

10064

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>W.</u> Middle <u>Henry</u> Last <u>Bowen</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 1, 1877</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Cabret Co., Ind</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. Henry Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Buckler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Thomas Bowen - Huntingtown, Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-10-1950</u> to <u>9-20-1959</u> , that I last saw the deceased alive on <u>9-18-1959</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>26 Sept. 59</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. PHYSICIAN'S NAME (Type) <u>B. J. WEEMS</u> <u>PRINCE FREDERICK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Deland Ind, Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Q. [Signature]</u>				ADDRESS <u>How - Mutual, Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

1-1-1900

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Jan 1, 1900</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Occupation: <u>Teacher</u></p>		<p>8. Marital status: <u>Married</u></p>	
<p>9. Name of informant: <u>John Doe</u></p>		<p>10. Signature of informant: <u>[Signature]</u></p>	
<p>11. Name of physician: <u>Dr. Smith</u></p>		<p>12. Signature of physician: <u>[Signature]</u></p>	
<p>13. Name of registrar: <u>John Doe</u></p>		<p>14. Signature of registrar: <u>[Signature]</u></p>	
<p>15. Name of hospital: <u>St. Mary's</u></p>		<p>16. Signature of hospital: <u>[Signature]</u></p>	
<p>17. Name of funeral home: <u>John Doe</u></p>		<p>18. Signature of funeral home: <u>[Signature]</u></p>	
<p>19. Name of cemetery: <u>St. Mary's</u></p>		<p>20. Signature of cemetery: <u>[Signature]</u></p>	
<p>21. Name of church: <u>St. Mary's</u></p>		<p>22. Signature of church: <u>[Signature]</u></p>	
<p>23. Name of school: <u>St. Mary's</u></p>		<p>24. Signature of school: <u>[Signature]</u></p>	
<p>25. Name of other institution: <u>St. Mary's</u></p>		<p>26. Signature of other institution: <u>[Signature]</u></p>	
<p>27. Name of other institution: <u>St. Mary's</u></p>		<p>28. Signature of other institution: <u>[Signature]</u></p>	
<p>29. Name of other institution: <u>St. Mary's</u></p>		<p>30. Signature of other institution: <u>[Signature]</u></p>	
<p>31. Name of other institution: <u>St. Mary's</u></p>		<p>32. Signature of other institution: <u>[Signature]</u></p>	
<p>33. Name of other institution: <u>St. Mary's</u></p>		<p>34. Signature of other institution: <u>[Signature]</u></p>	
<p>35. Name of other institution: <u>St. Mary's</u></p>		<p>36. Signature of other institution: <u>[Signature]</u></p>	
<p>37. Name of other institution: <u>St. Mary's</u></p>		<p>38. Signature of other institution: <u>[Signature]</u></p>	
<p>39. Name of other institution: <u>St. Mary's</u></p>		<p>40. Signature of other institution: <u>[Signature]</u></p>	
<p>41. Name of other institution: <u>St. Mary's</u></p>		<p>42. Signature of other institution: <u>[Signature]</u></p>	
<p>43. Name of other institution: <u>St. Mary's</u></p>		<p>44. Signature of other institution: <u>[Signature]</u></p>	
<p>45. Name of other institution: <u>St. Mary's</u></p>		<p>46. Signature of other institution: <u>[Signature]</u></p>	
<p>47. Name of other institution: <u>St. Mary's</u></p>		<p>48. Signature of other institution: <u>[Signature]</u></p>	
<p>49. Name of other institution: <u>St. Mary's</u></p>		<p>50. Signature of other institution: <u>[Signature]</u></p>	
<p>51. Name of other institution: <u>St. Mary's</u></p>		<p>52. Signature of other institution: <u>[Signature]</u></p>	
<p>53. Name of other institution: <u>St. Mary's</u></p>		<p>54. Signature of other institution: <u>[Signature]</u></p>	
<p>55. Name of other institution: <u>St. Mary's</u></p>		<p>56. Signature of other institution: <u>[Signature]</u></p>	
<p>57. Name of other institution: <u>St. Mary's</u></p>		<p>58. Signature of other institution: <u>[Signature]</u></p>	
<p>59. Name of other institution: <u>St. Mary's</u></p>		<p>60. Signature of other institution: <u>[Signature]</u></p>	
<p>61. Name of other institution: <u>St. Mary's</u></p>		<p>62. Signature of other institution: <u>[Signature]</u></p>	
<p>63. Name of other institution: <u>St. Mary's</u></p>		<p>64. Signature of other institution: <u>[Signature]</u></p>	
<p>65. Name of other institution: <u>St. Mary's</u></p>		<p>66. Signature of other institution: <u>[Signature]</u></p>	
<p>67. Name of other institution: <u>St. Mary's</u></p>		<p>68. Signature of other institution: <u>[Signature]</u></p>	
<p>69. Name of other institution: <u>St. Mary's</u></p>		<p>70. Signature of other institution: <u>[Signature]</u></p>	
<p>71. Name of other institution: <u>St. Mary's</u></p>		<p>72. Signature of other institution: <u>[Signature]</u></p>	
<p>73. Name of other institution: <u>St. Mary's</u></p>		<p>74. Signature of other institution: <u>[Signature]</u></p>	
<p>75. Name of other institution: <u>St. Mary's</u></p>		<p>76. Signature of other institution: <u>[Signature]</u></p>	
<p>77. Name of other institution: <u>St. Mary's</u></p>		<p>78. Signature of other institution: <u>[Signature]</u></p>	
<p>79. Name of other institution: <u>St. Mary's</u></p>		<p>80. Signature of other institution: <u>[Signature]</u></p>	
<p>81. Name of other institution: <u>St. Mary's</u></p>		<p>82. Signature of other institution: <u>[Signature]</u></p>	
<p>83. Name of other institution: <u>St. Mary's</u></p>		<p>84. Signature of other institution: <u>[Signature]</u></p>	
<p>85. Name of other institution: <u>St. Mary's</u></p>		<p>86. Signature of other institution: <u>[Signature]</u></p>	
<p>87. Name of other institution: <u>St. Mary's</u></p>		<p>88. Signature of other institution: <u>[Signature]</u></p>	
<p>89. Name of other institution: <u>St. Mary's</u></p>		<p>90. Signature of other institution: <u>[Signature]</u></p>	
<p>91. Name of other institution: <u>St. Mary's</u></p>		<p>92. Signature of other institution: <u>[Signature]</u></p>	
<p>93. Name of other institution: <u>St. Mary's</u></p>		<p>94. Signature of other institution: <u>[Signature]</u></p>	
<p>95. Name of other institution: <u>St. Mary's</u></p>		<p>96. Signature of other institution: <u>[Signature]</u></p>	
<p>97. Name of other institution: <u>St. Mary's</u></p>		<p>98. Signature of other institution: <u>[Signature]</u></p>	
<p>99. Name of other institution: <u>St. Mary's</u></p>		<p>100. Signature of other institution: <u>[Signature]</u></p>	

MAILED
JAN 1 1900
BALTIMORE

10065

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>	c. LENGTH OF STAY IN 1b <u>81 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Levin</u> Middle <u>Cox</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James Nelson Cox</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Ellen Gibson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs Frank Penn</u> Address <u>Huntingtown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2 June</u> , 19 <u>57</u> , to <u>9 Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 Sept</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. L. Weems</u>		ADDRESS (Street, city or town, state) <u>Huntingtown Md</u> DATE SIGNED <u>9-9-59</u>	
PHYSICIAN'S NAME (Type) <u>G. L. Weems</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meranda</u>	22d. LOCATION (City, town, or county) (State) <u>Huntingtown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hatchis Funeral Home</u>		ADDRESS <u>Quiring Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>SEP 14 59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10046

10066 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		STATE <u>Maryland</u> COUNTY <u>Calvert</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Life</u>		LENGTH OF STAY (In this place) <u>Life</u>		CITY OR TOWN <u>Owings--</u>		CITY OR TOWN <u>Owings--</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At Home--</u>		STREET ADDRESS (If rural give location)		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Owings, Maryland.</u>		STREET ADDRESS	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Annie (-) Creek</u>				<u>Sep. 12, 1959</u>			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 14, 1893</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Susie Ella Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Phillip Creek Owings, Maryland.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331x IMMEDIATE CAUSE (A) <u>Cerebral aneurysm</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1959</u> to <u>9/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/10</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. Weems</u>				ADDRESS (Street, city, town, state) <u>Huntingtown, Md.</u>		DATE SIGNED <u>9/12/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-15-59</u>		NAME OF CEMETERY OR CREMATORY <u>Union Chapel Church Cem.</u>		LOCATION (City, town, or county) (State) <u>Bristol Road, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur A. Evans</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leroy Berry</u>		ADDRESS <u>Huntingtown, Md.</u>	
DATE <u>SEP 15 '59</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10067
CERTIFICATE OF DEATH

10047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b <u>1304 108</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert's Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Beach</u> d. STREET ADDRESS <u>1304 108</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rusan Elizabeth Donnelly</u> First Middle Last		4. DATE OF DEATH <u>Sept 19 1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 18 1959</u> 9. AGE (In years last birthday) <u>1 day</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Donnelly</u>		14. MOTHER'S MAIDEN NAME <u>Jean Dwyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr Daniel Donnelly</u> 17. INFORMANT <u>Boy 108 N. Beach</u> Address	

18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity (6 1/2 months)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>nd</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>R de Villarreal</u> PHYSICIAN'S NAME (Type) <u>R de Villarreal</u>	ADDRESS (Street, city or town, state) <u>St Thomas</u> DATE SIGNED <u>9/19/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>
22d. LOCATION (City, town, or county) <u>Wash. D.C.</u> (State)		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hitchin Funeral Home Owens Rd</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>

2064 317XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTHS AND DEATHS BUREAU OF VITAL RECORDS

1903

NAME OF DECEASED

AGE

RESIDENCE

SEX

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

NAME OF MOTHER

NAME OF FATHER

NAME OF MOTHER

NAME OF FATHER

NAME OF MOTHER

NAME OF FATHER

NAME OF MOTHER

NAME OF FATHER

NAME OF MOTHER

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NAME OF FATHER

NAME OF MOTHER

NAME OF FATHER

NAME OF MOTHER

NAME OF FATHER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10048

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wintona</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert H</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick E. Fion</u>		4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Saunders</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Marion Russell, Prince Frederick, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was brought to H and died in a few mins</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>9 14 59</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Wintona</u>		(County) <u>Calvert</u>	
(State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>H W Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/15/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brooks</u>		22d. LOCATION (City, town, or county) <u>Island Creek</u>	
(State) <u>MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>P. J. Sewell, Prince Frederick, Md.</u>	
ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10049

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CALVERT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1921 KALORAMA RD. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LOWE Last HILLYER		4. DATE OF DEATH Month September Day 6 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug-2-1865
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lawyer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CURTIS J. HILLYER		14. MOTHER'S MAIDEN NAME ANGELINE ALEXANDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. CURTIS HILLYER		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES CO., WASHINGTON, D.C.		24a. REC'D BY REGISTRAR SEP 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

100

10070

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Clover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. H.</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Clyde</u> First Middle Last <u>Jones</u>				4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>R</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1906</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Benj. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Ladie Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x</u> DUE TO <u>Ischemic hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic Coma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Has had a black stroke for several days</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Died at 12:23 PM</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>12:23</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H W Ward</u>				ADDRESS (Street, city or town, state) <u>M.D. Owens</u>			
DATE SIGNED							
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Co. md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u> ADDRESS <u>Prince Frederick md.</u>				24a. REC'D BY REGISTRAR <u>SEP 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10050

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

10050

Wesley
BOND

Name of deceased		Wesley	
Sex		Male	
Age		28	
Date of death		10-1-50	
Place of death		Home	
Cause of death		Heart disease	
Disease or injury		Coronary artery disease	
Occupation		Salesman	
Usual residence		10050	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	
Date of registration		10-1-50	
Place of registration		Baltimore	
Registrar's name		[Name]	
Registrar's title		[Title]	
Registrar's address		[Address]	
Registrar's phone		[Phone]	
Registrar's fax		[Fax]	
Registrar's email		[Email]	
Registrar's website		[Website]	
Registrar's social media		[Social Media]	
Registrar's other contact info		[Other Contact Info]	

10071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabert County Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Pearl Ethel King</u>		4. DATE OF DEATH <u>Sept. 10, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR <u>8</u> Months <u>12</u> Days <u>12</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Cabert County, Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin R. Buckmaster</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Brightwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Robert King - Sunderland, Ind</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO <u>Ca. of Cervix & uterus</u> (c) <u>Ca. of Cervix & uterus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>171X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 31, 1959</u> to <u>Sept 10, 1959</u> , that I last saw the deceased alive on <u>Sept 10, 1959</u> , and that death occurred at <u>3p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. De Villareal</u> M.D.		ADDRESS (Street, city or town, state) <u>St. Paul</u> DATE SIGNED <u>9/11/59</u>	
PHYSICIAN'S NAME (Type) <u>R. DE VILLAREAL</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Frederick, Ind</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Warkness & Son - Mutual, Ind</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>SEP 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10052

10072

Item 9 Film 6248 9-11-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crunk</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring MD</u> d. STREET ADDRESS <u>9012 FAIRVIEW ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>James Paul Kirkpatrick</u> First Middle Last 4. DATE OF DEATH <u>9</u> Month <u>2</u> Day <u>1959</u> Year			5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1896</u> 9. AGE (In years last birthday) <u>63</u> 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Hotel</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u> 11. BIRTHPLACE (State or foreign country) <u>Mo Missouri</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Regina Kirkpatrick</u> Lucy Ralph		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> WW # <u>1</u> 16. SOCIAL SECURITY NO. <u>577-05-6131</u> 17. INFORMANT <u>Regina Kirkpatrick</u> Address <u>9012 Fairview Rd</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) <u>Cerebral embolism</u> <u>586X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Salt Glaucoma disease</u> (c) <u>2 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>8</u> Hour <u>9</u> p.m. <u>2</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H.W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/2/59</u>	
EXAMINER'S NAME (Type) <u>H.W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zuka</u>	
24a. REC'D BY REGISTRAR <u>SEP 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>		24c. DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 12 Film G248 9-14-59 et
10073
CERTIFICATE OF DEATH

10053

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabot & Young Home</u>		d. STREET ADDRESS <u>15X-2</u>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>Ann</u> Middle <u>Martin</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 13, 1878</u>
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R N</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm A Martin</u>		14. MOTHER'S MAIDEN NAME <u>G. Weelin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>XXXX-XX-XXXX</u>	
17. INFORMANT <u>Winning Home Chart, P.F. Wg</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular disease</u> 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured left hip</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8/24/59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell in bathroom and hit by</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in bathroom</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1030</u> p.m. <u>8 24 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N. Home</u>		20f. (City or town) <u>Prince Fredrick</u> (County) <u>Cabot</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.		ADDRESS (Street, city or town, state) <u>Owings MD</u> DATE SIGNED <u>9/18/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 9-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u>		22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gulm M. Saylor</u> ADDRESS <u>Annapolis MD</u>		24a. REC'D BY REGISTRAR <u>SEP 10 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

CERTIFICATE OF DEATH

10023

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is heavily obscured by faint, illegible handwriting and numerous diagonal lines.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG248 9-17-59 et

10074

CERTIFICATE OF DEATH

10054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Wesley Marshall</u> First Middle Last 4. DATE OF DEATH <u>9</u> <u>7</u> <u>1959</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>E</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1894?</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Berg Marshall</u> 14. MOTHER'S MAIDEN NAME <u>Mary Earl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>216-16-4874</u> 17. INFORMANT <u>Mr. Chas Marshall, Sunderland</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular conditions 4 yrs</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead at a farm</u> INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>7-9</u> <u>7</u> <u>1959</u> Hour <u>a.m.</u> <u>p.m.</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Sunderland</u> (County) <u>Calvert</u> (State) <u>Md</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>H W Ward</u> M.D. <u>During</u> PHYSICIAN'S NAME (Type) <u>Ward</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-11-59</u> 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY <u>mt Hope</u> 22d. LOCATION (City, town, or county) (State) <u>Calvert Co. md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u> ADDRESS <u>Prince Frederick</u> 24a. REC'D BY REGISTRAR <u>SEP 14 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Chas S. House</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crofton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crofton</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Christman</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>9</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April</u>
9. AGE (in years and birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salvage Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Moore</u>		14. MOTHER'S MAIDEN NAME <u>Rachel A. Moore, nee Lushy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Calvin Lushy</u>		Address <u>Crofton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brown</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>850X</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell over board when boat turned over</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>9/1/59</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Felton Creek</u>		20f. (City or town) <u>Crofton</u> (County) <u>Calvert</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u> EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>Sept. 4, 59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>P</u>		22d. LOCATION (City, town, or county) (State) <u>Little Rock, Md. N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell Prince, Fred, Md</u>		24a. REC'D BY REGISTRAR <u>SEP 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Farris</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10056

10076

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>SEA</u>	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u>		c. LENGTH OF STAY IN 1b <u>1 wk</u>	
4. NAME OF HOSPITAL (If not in hospital, give street address) <u>Calvert Co. Hospital</u>		d. STREET ADDRESS <u>02X-2</u>	
5. NAME OF DECEASED (Type or print) <u>Thomas Michael Pruitt</u>		6. DATE OF DEATH <u>9</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u>	
7. SEX <u>M</u>	8. COLOR OR RACE <u>W</u>	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10. DATE OF BIRTH <u>May 14 1899</u>
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. BIRTHPLACE (State or foreign country) <u>MD</u>	
14. FATHER'S NAME <u>R S Pruitt</u>		15. MOTHER'S MAIDEN NAME <u>Marion Pruitt</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>yes</u>		17. SOCIAL SECURITY NO. <u>218-12-9648</u>	
18. INFORMANT <u>Mrs 2. H. Pruitt, Baltimore MD</u>		19. ADDRESS <u>MD</u>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Tobacco Pneumonia</u> DUE TO (c) <u>4 day</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/14</u> , 19 <u>59</u> , to <u>9/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>59</u> , and that death occurred at <u>5:17 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H W Ward</u>		DATE SIGNED <u>9/28/59</u>	
PHYSICIAN'S NAME (Type) <u>Drump MD</u>		M.D. <u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Friendship Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Hardisty</u>		24a. REC'D BY REGISTRAR <u>SEP 23 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur B. Howard</u>		DATE <u>SEP 23 59</u>	

CERTIFICATE OF DEATH

10036

10036

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>		<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>Jan 15 1910</i></p>	
<p>5. PLACE OF BIRTH</p> <p><i>Boston, Mass.</i></p>		<p>6. OCCUPATION</p> <p><i>Teacher</i></p>		<p>7. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>8. MANNER OF DEATH</p> <p><i>Natural</i></p>	
<p>9. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>10. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>		<p>11. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>12. SIGNATURE OF WITNESSES</p> <p><i>John Doe</i></p>	
<p>13. DATE OF DEATH</p> <p><i>Jan 15 1910</i></p>		<p>14. TIME OF DEATH</p> <p><i>10:00 AM</i></p>		<p>15. PLACE OF DEATH</p> <p><i>Home</i></p>		<p>16. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>17. SIGNATURE OF WITNESSES</p> <p><i>John Doe</i></p>		<p>18. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>19. SIGNATURE OF WITNESSES</p> <p><i>John Doe</i></p>		<p>20. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

10077

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Huntingtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabaret County Hospital</u>				f. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie R. Rawlings</u>				4. DATE OF DEATH <u>Sept. 22, 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 16, 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cabaret Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Amos Wood</u>				14. MOTHER'S MAIDEN NAME <u>Rosie Bowen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Frank Rawlings - St. Leonard, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition Dehydration</u> <u>443X</u> DUE TO <u>Generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension C.D.</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 9, 1959</u> to <u>Sept 22, 1959</u> , that I last saw the deceased alive on <u>Sept 22, 1959</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edw. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>St. Leonard</u> DATE SIGNED <u>9/22</u>			
PHYSICIAN'S NAME (Type) <u>R DEVILLARREAL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 24 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Frederick, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Warkner Son - Mutual, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Adams</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10058

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE- <u>MD</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		c. LENGTH OF STAY IN 1b _____		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		d. STREET ADDRESS _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>John Nelson Saunders</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Nelson Saunders</u>				4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-12-1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>Chas Saunders</u>				14. MOTHER'S MAIDEN NAME <u>Emma</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>314-361908</u>		17. INFORMANT <u>Emma Saunders</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been sick over a month</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year <u>158</u> <u>9</u> <u>10</u> <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, lot, factory, street, office bldg., etc.) <u>Home Huntingtown Calvert MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H W Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/10/59</u>	
EXAMINER'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-13-59</u>		22b. DATE THEREOF <u>9-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bonnie</u>		22d. LOCATION (City, town, or county) (State) <u>Stained Creek Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Frederick</u>				ADDRESS _____		24a. REC'D BY REGISTRAR <u>SEP 17 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF REPORTER	
22. SIGNATURE OF CLERK		23. SIGNATURE OF RECORDER		24. SIGNATURE OF INDEXER	
25. SIGNATURE OF FILE CLERK		26. SIGNATURE OF ARCHIVIST		27. SIGNATURE OF ASSISTANT	
28. SIGNATURE OF DEPUTY		29. SIGNATURE OF CHIEF		30. SIGNATURE OF DIRECTOR	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10059

Reg. Dist. No.

10080

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelina</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelina</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elenwood</u> First <u>White</u> Middle <u>W</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13/59</u>
9. AGE (In years last birthday) <u>2</u> yrs. <u>10</u> Months <u>18</u> Days <u>0</u> Hours <u>0</u> Min.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Hubert White</u>		14. MOTHER'S MARRIED NAME <u>Lillian Offer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Lillian White Jim Fredrick</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper respiratory infection</u> DUE TO <u>475X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>475X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> a. m. <u>9/23</u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Adelina</u> (County) <u>Calvert</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-24-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Carrolls</u>		22d. LOCATION (City, town, or county) <u>Barstow</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Jr. Frederick</u> ADDRESS <u>2064 181XU5</u>		24a. REC'D BY REGISTRAR <u>SEP 28 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Occupation		10. Education		11. Marital Status		12. Social History	
13. Medical History		14. Present Illness		15. Postmortem Examination		16. Signature of Examiner	
17. Signature of Physician		18. Signature of Coroner		19. Signature of Registrar		20. Signature of Burial Officer	
21. Signature of Undertaker		22. Signature of Funeral Home		23. Signature of Cemetery		24. Signature of Burial Place	
25. Signature of Burial Officer		26. Signature of Burial Officer		27. Signature of Burial Officer		28. Signature of Burial Officer	
29. Signature of Burial Officer		30. Signature of Burial Officer		31. Signature of Burial Officer		32. Signature of Burial Officer	
33. Signature of Burial Officer		34. Signature of Burial Officer		35. Signature of Burial Officer		36. Signature of Burial Officer	
37. Signature of Burial Officer		38. Signature of Burial Officer		39. Signature of Burial Officer		40. Signature of Burial Officer	
41. Signature of Burial Officer		42. Signature of Burial Officer		43. Signature of Burial Officer		44. Signature of Burial Officer	
45. Signature of Burial Officer		46. Signature of Burial Officer		47. Signature of Burial Officer		48. Signature of Burial Officer	
49. Signature of Burial Officer		50. Signature of Burial Officer		51. Signature of Burial Officer		52. Signature of Burial Officer	
53. Signature of Burial Officer		54. Signature of Burial Officer		55. Signature of Burial Officer		56. Signature of Burial Officer	
57. Signature of Burial Officer		58. Signature of Burial Officer		59. Signature of Burial Officer		60. Signature of Burial Officer	
61. Signature of Burial Officer		62. Signature of Burial Officer		63. Signature of Burial Officer		64. Signature of Burial Officer	
65. Signature of Burial Officer		66. Signature of Burial Officer		67. Signature of Burial Officer		68. Signature of Burial Officer	
69. Signature of Burial Officer		70. Signature of Burial Officer		71. Signature of Burial Officer		72. Signature of Burial Officer	
73. Signature of Burial Officer		74. Signature of Burial Officer		75. Signature of Burial Officer		76. Signature of Burial Officer	
77. Signature of Burial Officer		78. Signature of Burial Officer		79. Signature of Burial Officer		80. Signature of Burial Officer	
81. Signature of Burial Officer		82. Signature of Burial Officer		83. Signature of Burial Officer		84. Signature of Burial Officer	
85. Signature of Burial Officer		86. Signature of Burial Officer		87. Signature of Burial Officer		88. Signature of Burial Officer	
89. Signature of Burial Officer		90. Signature of Burial Officer		91. Signature of Burial Officer		92. Signature of Burial Officer	
93. Signature of Burial Officer		94. Signature of Burial Officer		95. Signature of Burial Officer		96. Signature of Burial Officer	
97. Signature of Burial Officer		98. Signature of Burial Officer		99. Signature of Burial Officer		100. Signature of Burial Officer	

10081

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>			
c. LENGTH OF STAY IN 1b <u>9 days</u>				d. STREET ADDRESS <u>—</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabaret County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>M.</u> Last <u>Wilkes</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10, 1883</u>	
				9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Cabaret Co., Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Benjamin F. Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Rafford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Carol Wilkes Solomons, md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>Diabetes mellitus</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 21</u> , 19 <u>55</u> , to <u>Sept 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 28</u> , 19 <u>55</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>St Leonard</u> DATE SIGNED <u>9/29/59</u>			
PHYSICIAN'S NAME (Type) <u>R DE VITTA AREAL MD</u>				<u>- ST LEONARD, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 2, 1959</u>		<u>St. Pauls Cemetery</u>		<u>Lesby - Cabaret Co - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Warkner</u> ADDRESS <u>York - mutual, Md.</u>				24. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>OCT 2 '59</u>		<u>Arthur B. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

1951

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Race: *White*

4. Date of Birth: *Jan 1, 1900*

5. Date of Death: *Dec 31, 1950*

6. Place of Birth: *Baltimore, Md.*

7. Usual Residence: *123 Main St, Baltimore, Md.*

8. Cause of Death: *Heart Disease*

9. Duration of Illness: *2 weeks*

10. Place of Death: *Home*

11. Signature of Physician: *[Signature]*

12. Signature of Registrar: *[Signature]*

13. Date of Registration: *Jan 1, 1951*

DEPARTMENT OF HEALTH
BALTIMORE, MD.

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